NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected / Rulemaking Action

R20-6-1102	Amend
R20-6-1102.01	New Section
R20-6-1106	Amend
R20-6-1108	Amend
R20-6-1113	Amend
R20-6-1121	New Section
Appendix B	Amend
Appendix F	Amend

2. **The specific authority for the rulemaking, including both the authorizing statutes (general) and the statutes the rules are implementing (specific):**
   Authorizing statutes: A.R.S. §§ 20-143, 20-1133; 42 U.S.C. 1395ss

   Implementing statutes: A.R.S. §§ 20-142 and 20-143

3. **The effective date of the rules:**
   March 3, 1999

4. **A list of all previous notices appearing in the Register addressing the final rules:**
   Notice of Rulemaking Docket Opening: 4 A.A.R. 3051, October 16, 1998.
   Notice of Proposed Rulemaking: 4 A.A.R. 3433, October 30, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
   Name: Vista Thompson Brown, Executive Assistant for Policy Affairs

   Address: Arizona Department of Insurance
   2910 North 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8456

   Fax: (602) 912-8452

6. **An explanation of the rules, including the agency's reasons for initiating the rules:**
   These rule amendments are necessary to conform Arizona's Medicare Supplement insurance rules with recently adopted federal regulations pertaining to Medicare+Choice.

7. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rules and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:**
   None.

8. **A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

9. **The summary of the economic, small business and consumer impact:**
   The Department does not anticipate that the rule changes will economically impact the Department, small businesses, or public and private employers.

Consumers will experience slightly higher premiums for Medicare Supplement Insurance as a result of the actions of the federal government.

10. **A description of the changes between the proposed rules, including supplemental notices, and final rules:**
The Department did not make any changes to the text of the rules from the proposed rulemaking package to the final rulemaking package.

11. **A summary of the principal comments and the agency response to them:**
The Department held a public hearing on December 3, 1998, at the Department of Insurance, and closed the public record on December 4, 1998, at 5 p.m. The Department received public comments from the Health Insurance Association of America (HIAA) and BlueCross BlueShield of Arizona.

The comments from the HIAA suggested changes to Medicare Supplement insurance rules not included in this rule package. The Department will consider the HIAA's comments for a future rulemaking package.

The BCBS' comments relate to a circular letter issued by the Health Care Financing Administration (HCFA) requiring health plans to guarantee to eligible Medicare beneficiaries whose coverage is terminating, the issuance of any Medigap plans A, B, C, or F that are offered to new enrollees, without exclusions for preexisting conditions. The Department had already incorporated the changes required by HCFA into both the proposed and final rulemaking packages. Thus, There was no need for additional changes to address BCBS's comments.

The circular letter also raised an issue as to whether the Department should require insurers to offer Medicare Supplement insurance to persons under age 65 who are disabled or have end-stage renal disease. While this is an option under federal law, it is not a mandate. The HCFA circular letter clearly states that issuers not now selling these plans to disabled and end-stage renal disease beneficiaries under 65 are not required to begin to do so. The Department believes that it lacks statutory authority under A.R.S. § 20-1133, to mandate this result. The Department has statutory authority to adopt only the minimum regulations required by the federal government to assure that the state retains its primary enforcement authority over Medigap insurance. See A.R.S. § 20-1133. The Department did not make this change.

12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
None.

13. **Incorporations by reference and their location in the rules:**
None.

14. **Were these rules previously adopted as emergency rules?**
No.

15. **The full text of the rules follows:**

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section
R20-6-1102. Definitions
R20-6-1102.01. Creditable Coverage
R20-6-1106. Standard Medicare Supplement Benefit Plans
R20-6-1108. Open Enrollment
R20-6-1113. Required Disclosure Provisions
R20-6-1121. Guaranteed Issue for Eligible Persons
Appendix B. Medicare Supplement Coverage Plans
Appendix F. Medicare Disclosure Statements

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1102. Definitions
In this Article, the following definitions apply.

1. No change.
2. No change.
3. No change.
4. "Bankruptcy" means that a Medicare+Choice organization which is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Arizona.
5. "[ ]" means the amount or text within the brackets is subject to change or variation.

6.~~4.~~ No change.
7.~~5.~~ No change.
8.~~6.~~ No change.
9.~~7.~~ No change.
10.~~8.~~ No change.

11. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.
12. "Creditable coverage" means the type of insurance coverage described in § 20-6-1102.01.
13. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act).

14.~~9.~~ No change.
15.~~10.~~ No change.

16. "Insolvency" means that an issuer, licensed to transact the business of insurance in Arizona, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

17.~~11.~~ No change.
18.~~12.~~ No change.

19. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in P.L. 105-33 Title IV, Subtitle A, Ch. 1, § 1859, and includes:
    a. Coordinated care plans that provide health care services, including, but not limited to, health care services organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
    b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
    c. Medicare+Choice private fee-for-service plans.

21.~~13.~~ No change.
22.~~14.~~ No change.
23.~~15.~~ No change.
24.~~16.~~ No change.
25.~~17.~~ No change.
26.~~18.~~ No change.
27.~~19.~~ No change.
28. "Secretary" means the Secretary of the United States Department of Health and Human Services.
29.~~20.~~ No change.

R20-6-1102.01. Creditable Coverage

A. Creditable coverage means, with respect to an individual, coverage provided under:
    1. A group health plan;
    2. Any health insurance plan;
    3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
    4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. § 1928;
    5. Chapter 55 of Title 10 United States Code (CHAMPUS);
    6. A medical care program of the Indian Health Service or of a tribal organization;
    7. A state health benefits risk pool;
    8. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
    9. A public health plan as defined in federal regulation; or
    10. A health benefit plan under Section 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)].

B. Creditable coverage does not include:
    1. Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance;
    2. Coverage issued as a supplement to liability insurance;
    3. Liability insurance, including general liability insurance and automobile liability insurance;
    4. Workers' compensation or similar insurance;
    5. Automobile medical payment insurance;
    6. Credit-only insurance;
    7. Coverage for on-site medical clinics; or
    8. Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

C. Creditable coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan:
    1. Limited scope dental or vision benefits;
    2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these; and
    3. Other similar, limited benefits as are specified in federal regulations.

D. Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits:
    1. Coverage only for a specified disease or illness insurance, and
    2. Hospital indemnity or other fixed indemnity insurance.

E. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance:
    1. Medicare supplemental health insurance as defined in 42 U.S.C. § 1882(g)(1) of the Social Security Act;
    2. Coverage supplemental to the coverage provided in Chapter 55 of Title 10, United States Code (CHAMPUS); and
    3. Similar supplemental coverage provided to supplement coverage under a group health plan.

R20-6-1106. Standard Medicare Supplement Benefit Plans

A. No change.
B. No change.
C. No change.
D. No change.
E. No change.
    1. No change.
    2. No change.
    3. Standardized Medicare supplement benefit plan "C" shall include only ~~the following: The~~ core benefits ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (D)(3), and ~~R20-6-1105(D)(1)~~(D)(8) ~~respectively~~.
    4. Standardized Medicare supplement benefit plan "D" shall include only the ~~following: The~~ core benefits ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and at-home recovery benefits ~~as~~ described in R20-6-1105(D)(1), ~~and~~ (D)(2), ~~R20-6-1105~~(D)(8), and ~~R20-6-1105~~(D)(10) ~~respectively~~.
    5. Standardized Medicare supplement benefit plan "E" shall include only the ~~following: The~~ core benefits ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care ~~as~~ defined in R20-6-1105(D)(1), ~~and~~ (D)(2), ~~R20-6-1105(D)(1)~~ (D)(8), and (D)(9) ~~respectively~~.
    6. Standardized Medicare supplement benefit plan "F" shall include only the ~~following: The~~ core benefits ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (D)(3), ~~R20-6-1105~~(D)(5), and ~~R20-6-1105~~(D)(8) ~~respectively~~.
    7. Standardized Medicare supplement benefit high deductible plan "F" shall include only 100% of covered expenses following the payment of the annual high deductible plan "F" deductible.

a. The covered expenses include:
   i. The core benefit as defined in R20-6-1105(C),
   ii. The Medicare Part A deductible,
   iii. Skilled nursing facility care,
   iv. The Medicare Part B deductible,
   v. One hundred percent of the Medicare Part B excess charges, and
   vi. Medically necessary emergency care in a foreign country as defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(8).

b. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles.

c. The annual high deductible Plan "F" deductible is $1,500 for 1998 and 1999, and is based on a calendar year. The Secretary shall annually adjust the deductible to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

87. Standardized Medicare supplement benefit plan "G" shall include only the ~~following: The~~ core benefit ~~as~~ described in R20-6-1105(C)~~,~~ plus Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and at-home recovery benefit ~~as~~ described in R20-6-1105(D)(1), (D)(2), (D)(4), (D)(8), and (D)(10) ~~respectively~~.

98. Standardized Medicare supplement benefit plan "H" shall include only the ~~following: The~~ core benefit ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country ~~as~~ described in R20-6-1105(D)(1), (D)(2), (D)(6), and (D)(8) ~~respectively~~.

109. Standardized Medicare supplement benefit plan "I" shall include only the ~~following: The~~ core benefit ~~as~~ described in R20-6-1105(C)~~,~~ plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefits ~~as~~ defined in R20-6-1105(D)(1), (D)(2), (D)(5), (D)(6), (D)(8), and (D)(10) ~~respectively~~.

11.~~10.~~ Standardized Medicare supplement benefit plan "J" shall include only the ~~following: The~~ core benefit ~~as~~ described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit ~~as~~ described in R20-6-1105(D)(1)~~,~~ ~~(2),~~ through (D)(3), (D)(5), and (D) (7) through ~~(D)(8), (9), and~~ (10) ~~respectively~~.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only 100% of covered expenses following the payment of the annual high deductible plan "J" deductible.
   a. The covered expenses include:
      i. The core benefit defined in R6-20-1105(C),
      ii. The Medicare Part A deductible,
      iii. Skilled nursing facility care,
      iv. Medicare Part B deductible,
      v. One hundred percent of the Medicare Part B excess charges,
      vi. Extended outpatient prescription drug benefit,
      vii. Medically necessary emergency care in a foreign county,
      viii. Preventive medical care benefit, and
      ix. At-home recovery benefit defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(7) through (D)(10).
   b. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles.
   c. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

R20-6-1108. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant who submits an application for a policy or certificate before or during the 6-month period beginning with the 1st day of the 1st month in which an individual is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each issuer shall make available each Medicare supplement policy and certificate currently offered by the ~~available from an~~ issuer ~~shall be made available~~ to all applicants who qualify under this subsection, without regard to age.

B. An issuer shall not exclude benefits based on a preexisting condition if an applicant:
   1. Qualifies under subsection (A),
   2. Submits an application during the time period in subsection (A), and
   3. As of the date of application, has had a continuous period of creditable coverage of at least 6 months.

C. If an applicant meets the criteria listed in subsections (B)(1) and (B)(2), but has had a continuous period of creditable coverage that is less than 6 months, an issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

D.B. Except as provided in subsections (B) and (C) and R20-6-1119, subsection (A) ~~A~~ shall not be construed as preventing the exclusion of benefits under a policy or certificate~~,~~ during the 1st 6 months of coverage, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

R20-6-1113. Required Disclosure Provisions

A. No change.

B. No change.

C. No change.
   1. No change.
   2. No change.
   3. The outline of coverage consists of 4 parts:

a. A cover page,
b. Premium information,
c. A disclosure page, and
d. Charts displaying the features of each benefit plan offered by the issuer.

4. The outline of coverage shall be:
a. In the language and format prescribed in Appendix B, and
b. In at least 12-point type.

5. The cover page shall:
a. Show all plans A-J, and
b. Prominently identify all plans the issuer offers.

6. The cover page or the page immediately following the cover page shall prominently display all possible premiums and modes of payment.

~~The outline of coverage provided to applicants pursuant to this rule consists of 4 parts: a cover page, premium information, disclosure page, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix B in no less than 12-point type. The standard plans A-J shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and payment frequency shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.~~

74. No change.

D. No change.

R20-6-1121. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue
1. An eligible person is an individual described in subsection (B) who:
a. Applies to enroll under a Medicare supplement policy not later than 63 days after the date of the termination of enrollment described in subsection (B), and
b. Submits evidence of the date of termination or disenrollment with the application for the policy.

2. With respect to an eligible person, an issuer shall not:
a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (C) that is offered and is available for issuance to new enrollees by the issuer;
b. Discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; or
c. Impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

B. Eligible Person. An eligible person is an individual described in subsections (1) through (6) below:
1. The individual is enrolled under an employee welfare benefit plan that:
a. Provides health benefits that supplement the benefits under Medicare, and
b. Terminates or ceases to provide all supplemental health benefits to the individual;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply:
a. The organization's or plan's certification has been terminated or the organization terminated or otherwise discontinued providing the plan in the area in which the individual resides;
b. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
c. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
i. The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including a failure to timely provide the individual with medically necessary care for which benefits are available under the plan, or a failure to provide covered care in accordance with applicable quality standards;
ii. The organization, agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
iii. The individual meets other exceptional conditions as the Secretary may provide;

3. The individual is enrolled with an organization listed in this subsection and the enrollment ceased under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (B)(2):
a. An eligible organization under a contract under Section 1876 (Medicare risk or cost);
b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
c. An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
d. An organization under a Medicare Select policy; and

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization;
b. Of other involuntary termination of coverage or enrollment under the policy;
c. The issuer of the policy substantially violated a material provision of the policy; or
d. The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5. The individual meets both of the following conditions:
a. The individual was enrolled under a Medicare supplement policy, terminates that enrollment, and subsequently enrolls for the 1st time, with:
i. Any Medicare+Choice plan under Part C of Medicare,

ii. Any eligible organization under a contract under Section 1876 (Medicare risk or cost),

iii. Any similar organization operating under demonstration project authority,

iv. An organization under an agreement, under Section 1833(a)(1)(A) (health care prepayment plan), or

v. A Medicare Select policy; and

b. The individual terminates the subsequent enrollment under subsection (B)(5) during any period within the 1st 12 months of the subsequent enrollment (which the enrollee is allowed to do under Section 1851(e) of the Social Security Act); or

6. The individual, upon 1st becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan not later than 12 months after the effective date of enrollment.

C. Products To Which Eligible Persons Are Entitled. An eligible person is entitled to the following Medicare supplement policy:

1. Under subsections (B)(1) through (B)(4): a Medicare supplement policy that has a benefit package classified as Plan A, B, C, or F offered by any issuer;

2. Under subsection (B)(5): the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not available, a policy described in subsection (C)(1); and

3. Under subsection (B)(6): any Medicare supplement policy offered by any issuer.

D. Notification provisions

1. At the time of an event described in subsection (B) that causes an individual to lose coverage or benefits due to the termination of a contract, agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated with the notification of termination.

2. At the time of an event described in subsection (B) that causes an individual to cease enrollment under a contract, agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Appendix B. Medicare Supplement Coverage Plans

[12 point]

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:

BENEFIT PLAN(s) _____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in Arizona ~~your state~~.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally [20]% of Medicare approved expenses).

Blood: First 3 pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	~~Basic~~ Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after you have paid a calendar year [$1,500] deductible. Benefits from high deductible plans F and J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and B, but do not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

Appendix B. Medicare Supplement Coverage Plans (*Continued*)

PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.

[for agents] Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:] [insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 'The Medicare Handbook' for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services~~.~~, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, and using uniform layout and format as shown in the charts below. No more than 4 plans may be shown on 1 chart. For purposes of illustration, charts for each plan are included in this appendix Article. An issuer may use additional benefit plan designations on these charts under ~~pursuant to~~ R20-6-1106.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

Appendix B. Medicare Supplement Coverage Plans - Plan A (*Continued*)

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$0	$[768 ~~764~~] (Part A Deductible)
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~]	$0	Up to $[96.00 ~~95.50~~] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan A (*Continued*)

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan B (*Continued*)

PLAN B
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~]	$0	Up to $[96.00 ~~95.50~~] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan B (*Continued*)

PLAN B
MEDICARE (PART B)-MEDICAL SERVICES- PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan C

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan C (*Continued*)

PLAN C
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan D**

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~](Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan D (*Continued*)

PLAN D
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans - Plan E

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~]a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan E

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts* (the Part B Deductible)	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts *	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[100] of Medicare-Approved Amounts*	$0	$0	$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B. Medicare Supplement Coverage Plans - Plan E *(Continued)*

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES-PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual ~~Annual~~ physical and preventive tests and services, such as: ~~fecal occult blood test,~~ digital rectal exam, ~~mammogram,~~ hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, ~~influenza shot,~~ tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan F will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan F will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts*	$0	$[100] (the Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Appendix B. Medicare Supplement Coverage Plans - Plan F (*Continued*)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved			

Amount *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS-NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

Appendix B. Medicare Supplement Coverage Plans - (*Continued*) - Plan G

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan G**

PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan H**

PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan H**

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan I**

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~] a day	$[192 ~~191~~] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~]a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			

First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan I**

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

No change.

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan J**

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[768 ~~764~~]	$[768 ~~764~~] (Part A Deductible)	$0
61st through 90th day	All but $[192 ~~191~~]] a day	$[192 ~~191~~]a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[384 ~~382~~] a day	$[384 ~~382~~] a day	$0
- Once lifetime reserve days are used:			

- Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[96.00 ~~95.50~~] a day	Up to $[96.00 ~~95.50~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

Appendix B. Medicare Supplement Coverage Plans (*Continued*) **- Plan J**

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,500] deductible. Benefits from the high deductible plan J will not begin until your out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare-Approved Amounts* (the Part B Deductible)	$0	$[100]	$0

Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[100] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Appendix B. Medicare Supplement Coverage Plans (*Continued*) - Plan J

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE** YOU PAY
OTHER BENEFITS-NOT COVERED BY MEDICARE			
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual ~~Annual~~ physical and preventive tests and services, such as: ~~fecal occult blood test,~~ digital rectal exam, ~~mammogram,~~ hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, ~~influenza shot,~~ tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Appendix F. Medicare Duplication Disclosure Statements

MEDICARE DISCLOSURE STATEMENTS
Instructions for use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries

1. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

2. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person who already has a Medicare supplement policy except as a replacement policy.

3. Property/Casualty and Life insurance policies are not considered health insurance.

4. Disability income policies are not considered to provide benefits that duplicate Medicare.

5. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

6. ~~5.~~ The federal law does not preempt state laws that are more stringent than the federal requirements.

7. ~~6.~~ The federal law does not preempt existing state form filing requirements.

8. Section 1882 of the federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix F remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

Appendix F. Medicare Duplication Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Duplication Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Duplication Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ policies that reimburse expenses incurred for specified disease ~~disease(s)~~ or other specified impairments ~~impairment(s)~~. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for 1 of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for 1 of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

~~[For long-term care policies providing both nursing home and non-institutional coverage.]~~

~~IMPORTANT NOTICE TO PERSONS ON MEDICARE~~

~~THIS IS NOT MEDICARE SUPPLEMENT INSURANCE~~

~~**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**~~

~~Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.~~

- ~~This is long-term care insurance that provides benefits for covered nursing home and home care services.~~
- ~~In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.~~
- ~~This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.~~

~~**Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.**~~

~~**Before You Buy This Insurance**~~

- ~~Check the coverage in **all** health insurance policies you already have.~~
- ~~For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.~~
- ~~For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.~~
- ~~For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.~~

~~**Appendix F. Medicare Disclosure Statements** *(Continued)*~~
~~[For long-term care policies providing nursing home benefits only.]~~

~~IMPORTANT NOTICE TO PERSONS ON MEDICARE~~

~~**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**~~

~~**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**~~

~~Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.~~

- ~~This insurance provides benefits primarily for covered nursing home services.~~
- ~~In some situations Medicare pays for short periods of skilled nursing home care and hospice care.~~
- ~~This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.~~

~~**Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.**~~

~~**Before You Buy This Insurance**~~

- ~~Check the coverage in all health insurance policies you already have.~~
- ~~For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.~~
- ~~For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.~~
- ~~For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.~~

Appendix F. Medicare Disclosure Statements *(Continued)*
[For policies providing home care benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for ~~For~~ other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accident injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits for specified limited services]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review *the Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the policy conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.